DOCUMENT RESUME

ED 309 348 CG 021 809

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TITLE Goodbye Therapy: Use of Imagery Techniques for Problematic Grief Intervention.
PUB DATE Apr 87
NOTE 22p.; Paper presented at the Annual Meeting of the American Association for Counseling and Development (New Orleans, LA, April 21-25, 1987).
PUB TYPE Guides - Non-Classroom Use (055) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Anxiety; Client Characteristics (Human Services); *Counseling Techniques; Depression (Psychology); *Grief; *Imagery; Models

ABSTRACT

This document addresses the issue of problematic grief reactions, reactions which tend to be more common than are often realized and which may be a source of "existential" anxiety. It presents a treatment model which can be used with any loss-elicited grief reaction including the acute grief reaction typically encountered subsequent to the death of a close relative or friend, especially if the grief reaction becomes prolonged and unresolved. Variables which need to be assessed as determinants of the severity of the grief reaction and its prognosis are discussed, including intensity of the relationship, security involved in the attachment, degree of ambivalence, mode of separation, personality variables, social variables, and loss/grief history. The identification of obstacles to effective grieving is recommended. These barriers may include persistent desire for recovery of the loss object; the desire to express negative affect because of the loss but being unable to do so; difficulties in dealing with ambivalence and feelings of anger related to the loss; Pandora's box phenomenon; powerful covert contracts with the lost person or object; unfinished business and unexpressed secrets; reinforcement or secondary gain for inappropriate grief reactions; and absence of or limited coping skills and support network. The action phase of therapy incorporating the imagery restructuring technique is described as a systematic model consisting of these seven steps: structure; relaxation training; introduction of imagery; introduction of loss related images; imagery restructuring; coping imagery; and imagery projection. (ABL)

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Goodbye Therapy: Use of Imagery Techniques For Problematic Grief Intervention

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Running head: Loss and Grief

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Abstract

In this article the author provides an overview of the dynamics of loss and grief, suggests an expansion of the traditional perception of the loss-grief reaction and presents a specific therapeutic intervention for working with problematic grief reactions.

Loss and Grief: An Overview and Therapeutic Intervention

Beginning with the early seminal work of Lindemann (1944) and proceeding through a number of other writers including the major contributions of Kubler-Ross (1969; 1975), bereavement and grief have been examined systematically as a part of normal human functioning. As is the case with most human behaviors, the dynamics of grief and its related behaviors can become abnormal and dysfunctional and therefore the focus of the helping professions. This field of interest has grown rapidly in recent years (Parkes, 1985; Shackleton, 1984).

Most often, grief has been viewed as the emotional and cognitive consequences of the death of a loved one (Brammer, 1973; Dixon, 1979). More recently, and particularly for the focus of this paper, the connotation of grief has been expanded to include the reaction to any significant loss. The loss in question certainly may be but should not be perceived as limited to the death of a significant other. As part of the more recent grief literature, a number of therapeutic approaches or techniques have been offered to help with the "grief work" seen as necessary for effective and functional bereavement (Cates, 1986; Davidowitz & Myrick, 1984; Fulmer, 1983; Raphael, 1983; Speck, 1985; Whitaker, 1985).

Within this framework, the purpose of this paper is (a) to provide an overview of the psychological dynamics of loss and grief, (b) to introduce the concept of a generalized loss-grief reaction as a common but often overlooked problem worthy of therapeutic intervention, and (c) to present a therapeutic intervention for addressing the generalized dysfunctional loss-grief reaction.

Overview of Loss and Grief Dynamics

As groundwork for the specific therapeutic intervention presented, the following eight principles, concepts and interpretations are offered.

1. Grief is a universal reaction, unlike some other issues with which mental health professionals deal. Everyone does not experience alcoholism, divorce, severe depression, etc., but virtually everyone experiences significant loss and consequent grief.

2. A significant paradox exists concerning grief and relationships: as our interdependence on others increases and the consequent reinforcement from those relationships grows, so does the potential for intense grief.

3. Intense grief is easily recognized--depression, sadness, numbness, even denial--and the symptoms have a temporal relationship to the major loss. After a few days the numbness turns to intense suffering. There is a emptiness. The loss is repeatedly thought of while awake and even in dreams and hallucinations. Physical symptoms are also common--weakness, sleep disturbances, loss of appetite, headaches, back pain, indigestion, shortness of breath and even heart palpitations (Harvard Mental Health Letter, 1987).

4. Less recognized is the degree to which subtle separations and losses are faced continually. We often are not even aware of these or of our own grief reactions. The French have a term for these--<u>un petite morte</u>--the small deaths. Even when these losses are perceived and experienced, custom or pride often prevent catharsis, sharing, seeking help--grieving.

5. Many losses are significant because of their symbolic meaning. For example, a change in self-image or loss in regard to hopes and fantasies can produce grief. The phenomenological dynamics or personal perception at work in many losses must be considered.

6. Each loss often carries with it the threat of additional loss. For example, the loss of health may lead to loss of skills, loss of job and loss of the role of "provider".

7. Loss is often overlooked as an etiologic agent for disease and dysfunction. There is evidence that grief has effects on mental and physical health. The rate of depression in widows and widowers, for example, a year after the death of the spouse, has been found to be from 16 to 36 percent. This is compared with 8 percent of comparable married persons who were depressed at some time during the year. Concerning physical health, bereavement has been linked to an increase in death rates for widows and widowers compared to comparable married individuals, to an increase in both high blood pressure and congestive heat failure and to increased suicide rates. One study found that suicide was 66 times more common among men and 10 times more common among women in the first week after loss of a spouse than in the general population at the same ages (Harvard Mental Health Letter, 1987).

8. As with other forms of anxiety, grief elicits various psychological defense mechanisms in many individuals: (a) Repression: Pushing guilt, shame or other unwanted feelings into the unconscious. (b) Displacement: Anger at the lost object or deceased may be displaced

to relatives, friends or others. (c) Rationalization: Because of "unacceptable" grief reactions such as anger or relief of physical symptoms, the individual may rationalize the grief. (d) Denial: Kubler-Ross (1969) has popularized this as a common stage of the terminally ill and it is common for other kinds of grief as well. (e) Reaction Formation: Rather than deal with anger or hate toward the lost object, sometimes the reverse is observed--"He was the greatest guy in the world." (f) Intellectualization: "Well, they lived a full life"; "One can't expect for marriage to last these days since we live so much longer now." (g) Regression: The individual reverts to past coping styles or methods of gaining gratification as when the self-reliant individual becomes extremely dependent, for example.

Grief Intervention Model

Generally, it can be said that individuals experiencing an unresolved grief reaction are irrationally attempting to redo, reunite with, or avoid the past, therefore leaving little emotional energy to deal with the present and future (Melges, 1980). The therapeutic intervention presented involves the use of an imagery restructuring approach to introduce effective coping mechanisms and deal with specific obstacles that inhibit a more proactive grieving on the part of the client.

As has been suggested earlier, problematic grief reactions tend to be more common than are often realized and may even be the source of a great deal of "existential" or "free-floating" anxiety that are encountered so often. The treatment model to be presented is offered for use with any loss-elicited grief

reaction including the acute grief reaction typically encountered subsequent to the death of a close relative or friend, especially if the grief reaction becomes prolonged and unresolved.

Assessment and Dynamics of the Grief Reaction

Grief is a universal process of attempting to cope with any personal loss. While there are some common symptoms--insomnia, gastro-intestinal upsets, weight loss, general malaise, difficulty in concentrating, restlessness, limited motivation and feelings of sadness, anger and guilt--there is a great deal of individual variance among individuals in the grief reaction. Consequently, there are no hard and fast guidelines for identifying "appropriate" as opposed to "inappropriate" or problematic grieving; there are individual as well as different cultural norms for responding to loss. Therefore, it is proposed that the client's perspective be the point of departure, i.e., a phenomenological perspective. If, from the client's perspective, there is a problem in working through a loss of any kind then it must be treated as a problematic grief reaction worthy of therapeutic intervention.

To aid counselor and client in the exploration and understanding of the grief reaction there are some key dynamics which must be taken into account in assessing or diagnosing a particular deficit as a problematic grief reaction rather than another form of depression, for example. One of these major issues is a temporal one. It is important to verify if the undesired emotional reactions on the part of the client began shortly after a specific loss by the client and if that particular loss still preoccupies the client's mind for longer than a year after it has occurred. Admittedly, this one-year rule of thumb is arbitrary. As a matter of fact, some studies have even suggested that a two-

to four-year period of grief may be "normal" for many individuals. Nevertheless, the one-year period is still the common rule of thumb (Harvard Mental Health Letter, 1987). The key is still the client's perception, however.

The therapeutic intervention presented here is designed to help clients satisfactorily work through the loss-elicited grief necessary for personal growth. This therapeutic technique easily fits the classic three-stage proces of therapy identified with Carkhuff (1969) and Egan (1982), i.e., exploration, understanding and action. In this case, the narrowing of the presenting problem to that of an unresolved grief reaction per se and the identification of specific obstacles that interfere with effective coping are accomplished during the exploration and understanding phases.

For example, there are several significant variables which need to be assessed as determinants of the severity or intensity of the grief reaction and its prognosis. Each of these will be addressed in detail.

1. Relationship to the loss object. This variable refers to psychological closeness. Look for these elements:
   a. Intensity of the relationship or tie: how much did the client love the person, position, place or other loss object? The more intense, the greater the grief.
   b. Security involved in the attachment: to what degree was the client's well-being and psychological safety tied to the loss object? If a person, was that person relied on as the decision maker? The greater the security tie, the greater the grief.
   c. Degree of ambivalence: how much disappointment and anger as well as love or affection are present? The greater the degree of

ambivalence, the greater the grief (Sanders,1988).

2. Mode of Separation. Here, the concern is with how the loss occurred. What were the dynamics like? Was the loss expected or unexpected? How much warning was there before being fired, being asked for a divorce, before the death? As a specific aspect of this variable, in the case of death, did it happen close by or far away? Generally, the more warning or lead time, the better. The possible exception is when anticipatory grief deprives the individual of possibilities still remaining in the relationship, as in a death (Parkes, 1975).

3. Personality Variables. Generally, the more assertive, outgoing, uninhibited, and "internal" (in the locus of control sense), the better the prognosis for dealing effectively with loss. The individual with a history of depressive tendencies generally is a poor risk for effective grief work (Vachon, et. al., 1982).

4. Social Variables. Here we look for any relevant social, family, cultural or religious factors. Especially relevant would be any variables that promote the expression of emotion such as would be the case in the Latin cultures, the Irish wake tradition or other such examples (Vachon, et. al., 1982).

5. Loss/Grief History. This is probably the most significant predictor of how someone will handle grief. It is the classic shibboleth that the best predictor of future behavior is past behavior. Here we look at factors such as: (a) the client's personal grief history; have they had experience in dealing with loss and was it a "good" experience? (b) the number and significance of life change events prior to the loss in

question, and (c) the loss/grief history of the client's family and significant others; what have the modeling experiences been like? (Parkes, 1975.)

A second essential facet of assessment to cover during this early stage of therapy is the identification of specific obstacles or "road blocks" to effective grieving. Many of these are common to the grief reaction and have been noted by several authors. Examples of the common barriers include:

1. Persistent desire for recovery of the loss object. This obstacle has been noted and emphasized by Bowlby (1973) as a cardinal sign of lack of coping with loss. In these instances, the client gives evidence of preoccupation for the loss object; in the case of death, for example, the survivor often refers to the deceased in the present tense rather than the past tense. Dreams of reunion are common. Actual or symbolic "linking objects", such as pictures, mementoes, or other factors associated with the loss are often reviewed, touched, or dwelled upon in order to maintain hopes for reunion.

2. The desire to express negative affect because of the loss but being unable to do so. Bowlby (1973) suggests that negative affects such as anger and crying are necessary responses that lead to the recognition that the loss is final. Clients who experience this obstacle have not allowed themselves the full expression of affect that would allow them to differentiate from and consequently give up the loss completely. The inability to cry or rave at the loss oftentimes is a

consequence of society's dictates to "maintain appropriate composure" at the actual time of the loss and, at a later time, such affect is typically perceived as inappropriate. Sometimes this inhibition of affect is mediated by projective identification, where the client guards against his own expression of affect by identifying with and caring for others who are involved in the grief situation. At other times, the initial grief response may be inhibited because the loss was "unacceptable" by society (e.g., suicide or being fired from a job) or where society feels the loss was appropriate (e.g., death from terminal cancer or divorce from an abusing spouse).

3. Difficulties in dealing with ambivalence and feelings of anger related to the loss. Research has shown that the closer and more positive the relationship with the loss object, the more difficult and prolonged the grief reaction when the loss occurs (Raphael, 1983). Such a loss involves not only the termination of ongoing reinforcement but also the interruption of anticipated future reinforcement, leading to the universal feelings of hopelessness and anger on the part of the grieving client. In addition, there is often guilt when the client recognizes any negative feelings toward the lost object, feelings which are a natural part of any relationship. As a consequence, these negative feelings, particularly anger, are not expressed at the lost object but may be misdirected at the self or others. The therapist also needs to be aware that

excessive self-blame often is a cover for anger directed at the self at "not having done enough to prevent the loss" or as a cover for guilt about being angry at the lost person or object.

4. Pandora's box phenomenon. Another potential road block to appropriate coping with loss occurs when a current loss serves to stimulate previously unresolved grief related to past losses that have never been completely resolved. From a psychodynamic perspective, the relationship between past and present losses, which may even be at the unconscious level, inhibits the person from focusing on the current loss for fear old conflicts will arise again. The client, from this perspective, is defending against being overwhelmed with grief reactions to a number of losses.

5. Powerful covert contracts with the lost person or object. Typically seen as an obstacle to coping by the surviving spouse, these unspoken loyalties are much like "contracts" made during marriage. Examples of such "contracts" in surviving spouses are: "I will not leave you like you left me" or "I will always obey you and stay by your side".

6. Unfinished business and unexpressed secrets. Particularly when the loss involves the death of a loved one, some persons experience an obstacle to coping by virtue of fearing that the deceased will then have knowledge of a carefully guarded secret, such as an extramarital love affair, greed for

inheritance, etc. This same obstacle appears with other kinds of losses as well, as when individuals feel that somehow they must keep the lost person or object "alive in their heart" so they will have a chance to express love, forgiveness, or other important messages which were never communicated prior to the loss.

7. Reinforcement or secondary gain for inappropriate grief reactions. This obstacle is common as when a surviving spouse continues to display "helpless" behaviors and other non-coping activity because of the social interaction, avoidance of responsibilities or other reinforcement that may result. The obstacle is also common with other forms of loss.

8. Absence of or limited coping skills and support network. The major obstacle to effective grief work and dealing with loss is the lack of effective coping skills and/or appropriate support networks. In the case of death, for example, what with the fragmentation of the modern extended family and the consequent breakdown in family support systems, many individuals have to begin from scratch to build such a social network when a spouse dies. The support that is available is oftentimes of a ritualistic, limited, and superficial nature. In addition, many individuals for various reasons simply do not possess adequate coping skills that serve effectively in the time of loss.

In summary, the therapist should be aware of any obstacles such as these

more common ones that interfere with effective grieving or coping with loss (Vachon and Stylianos, 1988).

As the therapist goes through the exploration and understanding stages just discussed, the groundwork for actual treatment is being laid. Once successful exploration and understanding have taken place, the therapist can begin to help the client to change. Simply understanding the nature of the problem often does not help the client to alleviate it; it is essential that clients consciously and deliberately restructure their cognitive and affective approach to the loss-elicited grief. Obviously, this therapeutic approach relies heavily on cognitive change approaches to therapy. The model also incorporates elements of grief counseling approaches discussed by Morrison (1978) and Melges and De Maso (1980).

Process and Techniques

The action phase of therapy incorporating the imagery restructuring technique is a systematic model consisting of the following seven distinct steps:

1. Structure. The first step of treatment entails a summarization of the nature of the unresolved grief reaction and proposed intervention procedures. The goal of this step is a final verification of the perceived nature of the problem by the therapist as well as anxiety alleviation that structuring provides. It is important to explain to clients that they will be asked to re-experience in their imagination the oftentimes vivid loss in question. It also is appropriate at this point to present the basic rationale of cognitive restructuring, using various examples to illustrate the general significance of cognition on behavior. With the acceptance of this basic

rationale, the groundwork is laid for the more complex application to the client's specific problem. Finally, the client is advised that even though the grief work may involve a great deal of emotion such as crying and even anger, the positive impact and relief that comes with effective grieving also will be experienced. At this point a commitment on the part of the client to this final action stage of therapy may be requested. The client's commitment at this stage is seen as very positive and oftentimes therapeutic in itself.

2. Relaxation training. Imagery restructuring begins by first training the client to relax. Any of the standard relaxation procedures with which the counselor may be familiar could be used. It is typically common for clients to feel some discomfort during initial relaxation training and consequently not be able to achieve a very deep relaxation level. It is helpful to assign relaxation practice homework at this point. In order to facilitate the client's practice at home, a recorded relaxation procedure on cassette tape can be used. It should be noted that for various reasons some clients have difficulty relaxing with any of the standard procedures. No matter how motivated they may appear, they find it difficult to respond and achieve significant relaxation. For such clients, more direct hypnosis techniques may be more successful than the relaxation approach. The induction of hypnosis may enhance the imaginative capacity of some clients and therefore

may be worth the additional time and effort. It is suggested that a subjective scale of anxiety be used and that the client is asked for self-reports throughout the relaxation training.

3. Introduction of imagery. Once the client has achieved a satisfactory level of relaxation the introduction of imagery is begun. This is accomplished by first aiding the client in achieving a deep level of relaxation. Once that level is reached a number of neutral or control scenes are described and the client is asked to imagine each scene as vividly as possible--"as if you are really there"--while still maintaining the relaxed state.

4. Introduction to loss related images. This step involves having the client recreate or "relive" various scenes associated with the loss object. The basic structure for these images is provided by the therapist based on data obtained during the earlier exploration stage of therapy. Details are filled in by the client. It should be noted at this point that oftentimes some of the major obstacles or essential details of those barriers to effective grieving are not brought to light until this stage. It should be noted too that the client is instructed to report the scene in the present tense as though it were happening now. Following this imagery step the client is asked to further review the images and note any particular data that have not been raised to this point. This step also provides information concerning the client's coping

skills that may not have been easily elicited earlier. Feedback using the subjective anxiety scale referred to above is elicited again for base-line data against which post-treatment data can be compared.

5. Imagery restructuring. In this step the client is asked to restructure aspects of the various loss scenes that may have interfered with effective coping. For example, a time alone with a significant friend where private good-byes can be said, a situation which was not the case at that time, could be created. Sometimes the therapist has to actively intercede in restructuring the scene (e.g., providing the opportunity for private dialogues; delaying the arrival of a moving van to allow for sufficient "good-bye" time; removing all visitors from the funeral home in order for the person to say a final good-bye in private). The key restructuring in this step typically involves the creation of privacy with significant others associated with the loss so that significant affective communication of both a positive and negative nature can be shared.

6. Coping imagery. In this step, now that the key loss scenes have been restructured, the client is instructed to actively get on with "unfinished business". This step often involves clients communicating with those significant others involved in the loss and in the case of a loss involving death, to do such things as: acknowledge the finality of the loss,

differentiate themselves from the deceased, express anger, deal with any ambivalent feelings, bring up any secrets or unspoken contracts that need to be discussed, express love and forgiveness, and even obtain permission form the deceased to develop new relationships and get on with life. In other words, the goal here is to actively remove or deal with the obstacles blocking effective grieving. This may involve "directive" work by the therapist, if needed. Again, feedback on the subjective anxiety scale for assessment is requested. The same principles are involved in other types of loss as well.

7. Imagery projection: The final step in the therapeutic intervention is one of imagined projection on the part of the client one year into the future. Clients are instructed to imagine themselves coping with the specific loss in question. Clients are instructed to fill in the details of the future image and report the success of their coping at that time. It should be noted that at this stage, as well as in the previous step, that the therapist may need to actively intercede in terms of providing specific coping strategies if the client appears to be blocked in this regard. The imagery projection step also serves as an assessment of the adequacy of the therapy intervention. It is generally felt that successful coping is indicated when the individual is able to recognize and accept negative as well as positive aspects of

the previous relationship or loss object, i.e., to deal with ambivalence.

For those clients who still are focusing on the past loss and have not experienced an adequate distancing effect in this projected test, it is suggested that key loss scenes be reintroduced thus allowing for additional practice in coping imagery. The therapist also needs to be aware of the possibility of factors in the client's environment that may be unintentionally promoting unresolved grief behaviors.

Conclusion

Grief and bereavement reactions, especially as they are considered over the full range of response to loss, are behaviors with which the mental health counselor must be equipped to deal. It is hoped that the overview of loss and grief dynamics, the expansion of grief dynamics to other than death-related issues and especially the presentation of a specific therapeutic technique to deal with grief will be helpful to the mental health counselor addressing the pervasive grief reaction.

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